North East **LHIN**

North East Local Health Integration Network

2012/13 Annual Report

Ontario
Local Health Integration Network

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Cover Photo: Robert Muraska (left), Sally Power and Robyn Flaxman enjoy staying fit by cross country skiing and snowshoeing in Northeastern Ontario's vast 400,000 square kilometres.

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Message from the Board Chair and CEO

This Annual Report details the NE LHIN's work to engage with fellow Northerners to improve access to care, where and when it's needed. The overall goal of NE LHIN local decision-making is to ensure Northern voices are heard and reflected in building a local health care system that provides the right care, in the right place, at the right time, and at the right cost.

Louise Paquette, CEO

Elaine Pitcher, Chair

A few highlights of achievements this past year include:

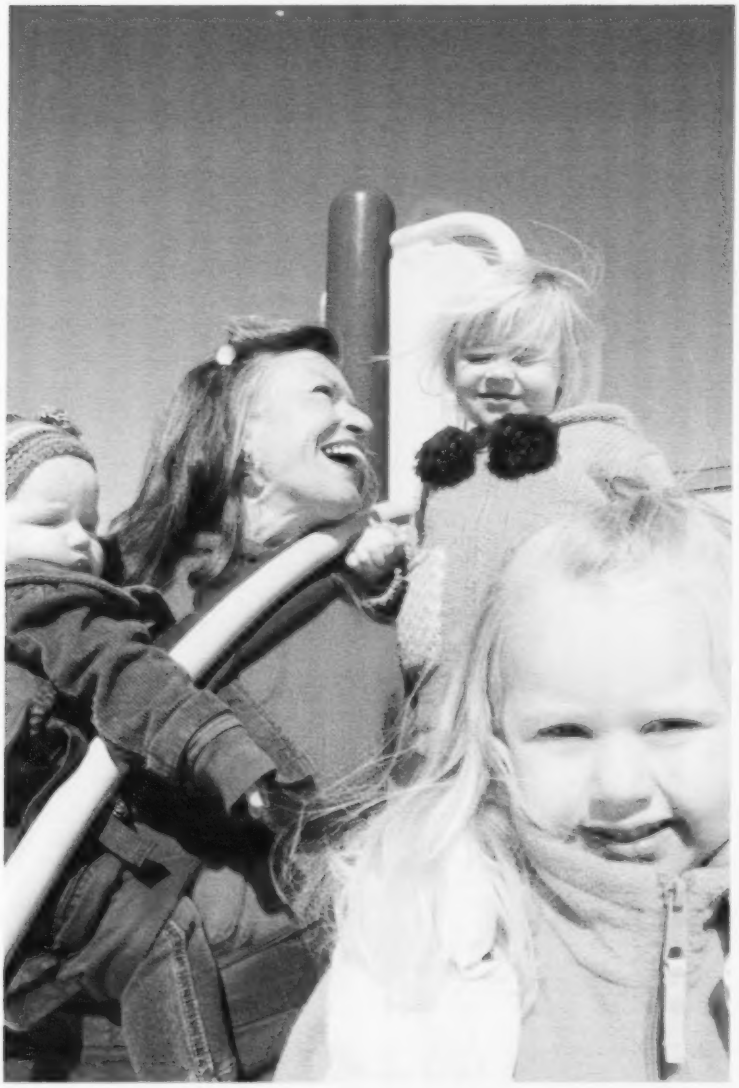
- Developing **realignment plans** for the Cochrane Hub and Temiskaming District and working with partners to realign health care services in the interest of enhanced patient care.
- Supporting two **Health Links** to improve the coordination of care for patients with complex conditions in the Timmins and Temiskaming areas. Health Links is a new model of care at the clinical level where all providers in a community coordinate care plans for patients.
- Releasing our **Integrated Health Service Plan (IHSP)** further to the input of more than 4,000 Northerners. Built by Northerners, for Northerners, the three-year plan has four regional health care priorities: increase primary care coordination; enhance care coordination and transitions to improve the patient experience; make mental health and substance abuse treatment services more accessible; and target the needs of culturally diverse populations.
- Completing the **Rehabilitation and Complex Continuing Care** review of our region and implementing its recommendations which will increase access and patient flow to rehab and CCC beds and services.
- Improving access to **mental health** services by investing in such initiatives as opiate addiction workers, nurses in schools and establishing a community crisis centre in Sudbury to care for individuals in community.
- Leading a two-day visit to **Hudson and James Bay communities** with our primary care lead, two North East geriatricians, and Dr. Samir Sinha, Provincial Seniors Strategy Lead, to learn about the challenges Elders and other residents along the coast face, and to offer solutions.
- Hosting four forums to highlight work being done across the region through unique collaborations, including: **Chronic Disease Management and Prevention, Telemedicine, Senior Falls Prevention, and Mental Health and Substance Abuse.**
- Increasing access to care through **technology-based investments** in telemedicine nurses, telehomecare and rapid response nurses.

As Northeastern Ontario's demographics shift to an aging population, our local health care system must keep pace and have programs and services that are aligned with the people who live here. The focus of our LHIN will continue to be engaging with fellow Northerners to ensure local decision-making benefits each one of us at home, in community, and as close to where we live as possible.

Elaine Pitcher, Chair

Louise Paquette, Chief Executive Officer

Welcome to the North East LHIN



Irene Fielding keeps active and healthy by playing with her grandchildren – Eliana Santos, six months, Mila Santos, 2, and Libby Giroux, 3. In Northeastern Ontario, 18% of the population is over the age of 65; a number that is projected to grow to 30% by 2036.

Mission:

To advance the integration of health care services across Northeastern Ontario by engaging our local communities.

« Favoriser l'intégration des services de santé dans le Nord-Est de l'Ontario en engageant nos communautés locales. »

Enkiichigaadeg waazhi maajiishkaang maamwizwin eni zhischigaadeg wii minoyaang naadmaadwin.
Giiwednowaabnong nikeya dinokiiwning ni zhischigaadeg wii minwaabminaagog endnokiishnang

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Vision:

Quality health care, when you need it.

Des services de santé de qualité au moment voulu.

Ezhi gshkitoong go waani zhi mino yang naadgo wendming pii ndo wendaagog.

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The North East LHIN Region

North East
Local Health Integration Network

HUB Planning Areas

This illustration depicts the North East LHIN's "HUB" planning areas. Planning areas have been determined by hospital referral patterns within the North East LHIN.

The North East LHIN covers 400,000 square kilometres and is home to 553,091 people.

North East LHIN Facts, Stats and Figures

Demographics:[1]

- 553,091 people dispersed over 400,000 square kilometres; more than 53% of our population live in small and rural population centres (less than 30,000 people).
- Declining population -- (5.4% since 1996) compared to provincial growth of about 20%.
- Minimal growth -- population is projected to increase by only 1% between 2011 and 2036.
- Older population -- 18% of people are aged 65+ as compared to 13% for Ontario. This number is expected to increase to 30% by 2036 (compared to 22% for Ontario).
- Culturally diverse -- close to 10% Aboriginal; 22% Francophone.

Health Service Providers:

Every year, the NE LHIN provides 1.4 billion dollars to 156 Health Service Providers to support 182 health programs across Northeastern Ontario. Agreements include:

- 115 Multi Sector Service Accountability Agreements (M-SAAs) – include community support services like meals on wheels and assisted living, as well as mental health and substance abuse providers
- 25 Hospital Service Accountability Agreements (H-SAAs)
- 42 Long-Term Care Home Service Accountability Agreements (L-SAAs).

Health Care Services:

- 538 family physicians, one Group Health Centre in Sault Ste. Marie (34 family physicians), 27 family health teams, six community health centres, six nurse practitioner-led clinics, 16 nursing stations, three Aboriginal health centres.
- Health Care Connect Program has helped Northerners connect with primary care providers. Between February 2009 and March 2013, 49,311 NE LHIN residents had registered with the program and nearly 70% had been referred to a family health care provider.
- 108 long-term care beds for every 1,000 people aged 75 and over (2012), as compared to 86 beds per 1,000 people aged 75 and over in Ontario.

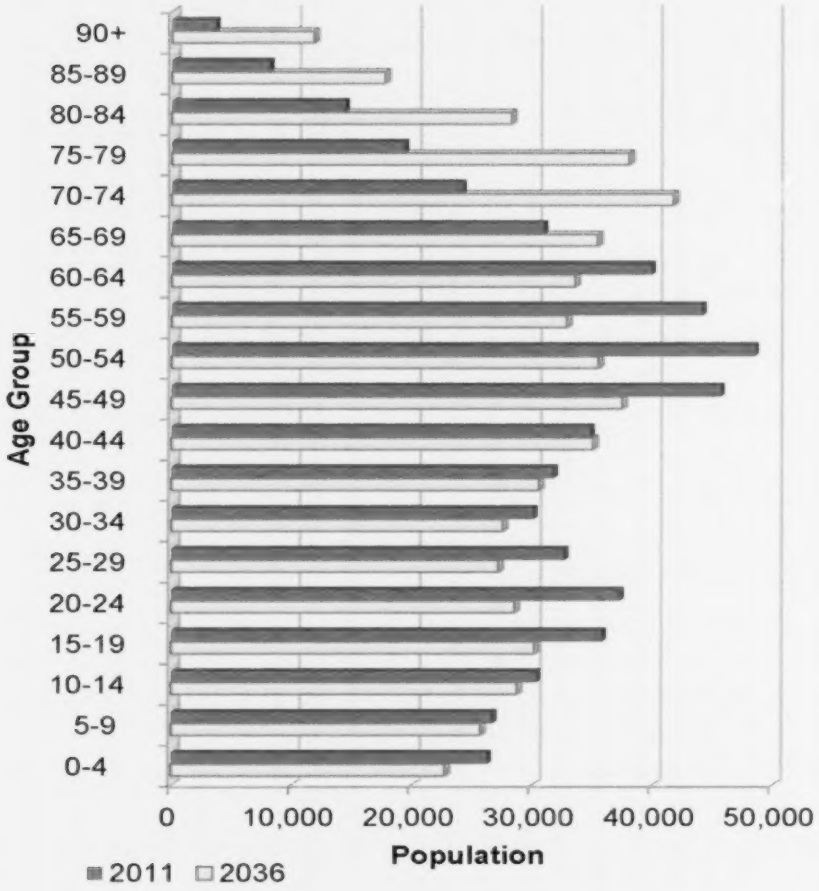
Margaret Jones, Dorothy Robidoux, and Iverna Whalen keep active and are social through weekly bowling with friends. In Northeastern Ontario, there is a higher than provincial average of people living with chronic diseases such as diabetes, arthritis and asthma.

[1] *Statistics Canada – 2011 Census*

Health Facts:[2]

- Shorter life expectancy than residents of Ontario: 76.5 years for males (79.2 years in Ontario), and 81.4 years for females (83.6 in Ontario).
- Premature mortality, a measure of death rates (per 100,000 population) prior to age 75, is 26% higher in the NE LHIN compared to the province.
- The leading causes of death for NE LHIN residents, as well as all Ontarians, are circulatory system diseases (such as heart disease and stroke) and neoplasms (cancer). The rate of circulatory system disease deaths (deaths per 100,000 population) are 22% higher in the NE LHIN than in Ontario; and neoplasms are 16% higher.
- A higher percentage of people living with chronic diseases than the rest of Ontario, including:
  - arthritis/rheumatism - 24% vs.17%
  - asthma - 9% vs. 8%
  - diabetes – at 8% vs. 7%

New/Emerging/Evolving Drivers of System Change



Population Change

The NE LHIN population is projected to change dramatically over the next 25 years.

The proportion of people age 65 and over is projected to increase from 18% to 30% by 2036.

The estimated number of seniors (65+) is projected to increase by 72%, from just over 100,000 to over 172,000 (note the provincial average is expected to increase by about 67%).

This significant demographic shift has major implications on the delivery of health care and the type and location of services delivered.

This figure shows the projected change in the population structure over a 25 year period (2011 population Census data - Ministry of Finance population projections)

[2] *Canadian Community Health Survey, 2010*

Overall, compared to the province, the North East has a higher:

	North East LHIN	Ontario*
Proportion of Aboriginal Identity	9.5%	2.0%
Proportion of Francophones	22%	4.4%
Proportion of people living in small and rural areas (less than 30,000)	53.2%	23.3%
Proportion of people over the age of 65	18%	14.6%
Unemployment rate for ages 15+	8.4%	6.4%
Proportion age 25 and over who do not have a post-secondary degree, diploma or certificate	18.4%	13.5%
Percentage of smokers	25.4%	19%
Percentage of drinkers reporting heavy drinking	19.9%	16.2%
Percentage of adults (age 18+) who are overweight or obese	61.7%	52.3%
Prevalence of high blood pressure	22.5%	17.4%
Percentage of residents with multiple chronic conditions	21.5%	15.2%

The North East region is also associated with a lower:

	North East LHIN	Ontario*
Proportion of the population who have a regular medical doctor	85.2%	90.9%
Proportion of the population rating their health as very good or excellent	57.9%	60.7%
Proportion of population reporting physical inactivity	44%	49%

(The information above is from Statistics Canada - both the 2011 Census and the Canadian Community Health Survey, 2010)
*Ontario percentages also include Northeastern Ontario percentages.

Elder Mary Rose Hughie and Virginia Wesley in Kachechewan during NE LHIN visit in February 2013. In Northeastern Ontario, close to 10% of the population is Aboriginal/First Nation/Métis as compared to a provincial average of 2%.

NE LHIN Board of Directors

Our Board of Directors is an active Board with enthusiastic and hard-working members who bring a wide variety of expertise to the table including law, accounting, medicine, management, as well as palliative and geriatric care.

Our Board members bring the face of the communities we serve to our governance table, and as we seek new board members, this breadth of skills and expertise will continue to be sought.

Elaine Pitcher
Chair
Sault Ste. Marie

Term: August 15, 2012 to August 14, 2015

Danielle Bélanger-Corbin
Vice Chair
Temiskaming Shores

Term: Sept. 29, 2010 to Sept. 28, 2013

Santina Marasco
Sudbury

Term: August 2012 to August 2015

Cecilia Bruno
Sault Ste. Marie

Term: June 1, 2011 to May 31, 2014

Dr. Colin Germond
Sudbury

Term: April 21, 2013 to April 21, 2016

Dr. Ian Cowan
North Bay

Term: February 2010 to February 2013

Minister Deb Matthews (left) visits with NE LHIN Primary Care Lead, Dr. Alan McLean, and NE LHIN Board Chair, Elaine Pitcher, at the Sault Area Hospital in February of 2013.

Ministry-LHIN Performance Agreement (MLPA)

The MLPA defines the relationship between the Ministry of Health and Long-Term Care and the NE LHIN in the delivery of local health care programs and services. The MLPA establishes a mutual understanding between the Ministry and the LHIN and outlines performance indicators within a defined period of time. Indicators are updated every quarter; for an up-to-date status report on indicators, please contact the NE LHIN or visit www.nelhin.on.ca.

	Performance Indicator	LHIN 2012/13 Starting Point	LHIN 2012/13 Performance Target	Most Recent Quarter 2012/13 LHIN Performance	% from Target for Most Recent Quarter Result*	FY 2012/13 LHIN Annual Result
Emergency Room/Alternate Level of Care						
1	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	32.1	22	27.4	25%	22%*
2	90th Percentile Emergency Room (ER) Length of Stay for Admitted (LOS) Patients	28.3	25	31	24%	29
3	90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	7.6	7	6.3	-10% (on target)	6.5
4	90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	4.7	4	4.2	5% (within performance corridor)	4.1
Surgical Wait Times						
5	90th Percentile Wait Times for Cancer Surgery	61	56	54	-3.6% (on target)	59
6	90th Percentile Wait Times for Cardiac By-Pass Procedures	31	49	37	-25% (on target)	53
7	90th Percentile Wait Times for Cataract Surgery	156	155	146	-6% (on target)	148
8	90th Percentile Wait Times for Hip Replacement	306	300	275	-8% (on target)	276
9	90th Percentile Wait Times for Knee Replacement	402	300	378	26%	393
Diagnostic Wait Times						
10	90th Percentile Wait Times for Diagnostic MRI Scan	106	65	37	-43% (on target)	47
11	90th Percentile Wait Times for Diagnostic CT Scan	29	28	32	14%	34
Excellent Care for All/Quality						
12	Readmission within 30 Days for Selected CMGs**	16.1%	15%	16.7%	11%	16.9**
Mental Health and Substance Abuse						
13	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions***	18.3%	16.5%	17.6%	7% (within performance corridor)	16.7**
14	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions**	26%	25%	25.4%	1.6% (within performance corridor)	26.9**
Access to Community Care						
15	90th Percentile Wait Time for CCAC In-Home Services Application from Community Setting to first CCAC Service* (excluding case management)	56	48	49	2% (within performance corridor)	59*

* FY 2012/13 is based on most recent four quarters of data (Q4 2011/12 – Q3 2012/13) due to availability

** FY 2012/13 is based on most recent four quarters of data (Q3 2011/12 to Q2 2012/13) due to availability

Report on MLPA Performance Indicators

NE LHIN wait times improved for a number of indicators in 2012/13. Improvements were seen in Alternate Level of Care and wait times for Emergency Room, MRI, Cancer and Cataract surgeries.

Emergency Room/Alternate Level of Care

Alternate Level of Care (ALC): Good progress was made in 2012/13 with the percentage of ALC days in acute care decreasing from over 30% to 20% through Q2 and increasing to 26.9% by Q3 due to planned hospital discharges. The NE LHIN continues to support a number of initiatives to help bring down ALC rates including: home first, assisted living, integrated discharge planning, assess and restore beds, behavioural supports for seniors in long-term care facilities, case managers in selected family health teams, and more.

Emergency Room (ER): ER length of stay (LOS) performance for admitted patients was below target for most of the year but increased above target in Q4 consistent with trends in the province and due largely to inpatient flow challenges related to ALC. Nine of 11 monitored sites maintained an ER LOS below 25 hours. ALC patient challenges in Sudbury, North Bay, and Timmins were a factor in patient flow from the ER to inpatient beds.

- For high acuity non-admitted patients: ER LOS performance improved. High acuity refers to people presenting themselves to the ER for urgent health care issues and who are categorized as "CTAS 1 to 3". Consistently 9 of 11 reporting sites maintained ER LOS below 7 hours and overall NE LHIN performance was below target at 6.5 hrs.

- For low-acuity non-admits: ER LOS performance improved from 4.7 to 4.2 hours. Eight of 11 monitored sites maintained ER LOS below provincial target of 4 hours.

- Strategies to reduce ER LOS include: the four HUB hospitals participating in the provincial ED Pay for Results program, introduction of community support system navigators, NE CCAC Care Coordinators in primary care settings, and others.

Surgical Wait Times

Cancer Surgeries: Cancer surgery wait times improved and were within target in Q3 and Q4. New surgeons (urology, ear nose and throat) in Sault Ste. Marie, where previously none existed, resulted in wait times increasing in this community as patients were previously sent out of town to receive specialized care. Improvement in wait times were realized by surgeons working together to ensure data quality for the wait times information system and addressing efficiencies.

Cardiac Surgeries: Wait times for cardiac by-pass surgery continued to stay below target in 2012/13. As the regional provider of cardiac by-pass surgery, Health Sciences North in Sudbury continued to demonstrate high performance in this area. A temporary surge in patient volume in the spring-summer months resulted in a temporary increase in wait times that was addressed with additional operating room time and a reduction in wait time by Q3. At Q4, wait time was 37 days, well below target (49).

Cataract Surgeries: Wait times for cataract surgeries improved and at Q4 were below target. High demand for cataract surgery and a province-wide reduction in volumes allocated to LHINs in 2012/13 was mitigated by efforts of NE LHIN hospitals to increase patient flow.

Hip Replacements: Wait times for hip replacement surgery improved by 10% and was below target. All surgical sites were able to complete volumes. The *NE LHIN's Integrated Orthopaedic Capacity Plan (IOCP)* establishes targets for quality and wait time performance, as well as an aggressive strategy to repatriate surgeries completed on residents outside of the region.

Over 50% of referrals have been redirected to conservative management or other care options enabling surgeons to focus on those patients requiring surgery. This is possible because of the standardized approach to assessment implemented by advanced practice physiotherapists who have received specialized training from orthopaedic surgeons in each of the five NE LHIN funded joint assessment centres (JACS). JACs provide the opportunity for patients to review surgeons' wait lists and opt to select the next available surgeon. Expanding the role of the JACs to other procedures will be explored in 2013/14.

Knee Replacements: Wait times for knee replacement improved by 6%, however still remained above target. (See related information above under Hip Replacements.) The *NE LHIN's Integrated Orthopaedic Capacity Plan* will assist in improving wait times in 2013/14, as will the increased use of joint assessment centres.

Diagnostic Wait Times

MRI Scans: Wait times for MRI scans improved in 2012/13. The marked decrease (from 106 days to 37 days) is due to the commitment of each site to MRI-PIP (Performance Improvement Program) which enabled hospitals to improve the efficiency of MRI scanning and increase patient flow. The first MRI scanner at the North Bay Regional Health Centre in May 2011 has assisted in lowering wait times.

CT Scans: Wait times for CT scans increased modestly in 2012/13 from 29 to 34 days at Q4. Very high demand for this modality, particularly in Sudbury (regional trauma centre, regional cancer centre), has contributed to the increase in wait times. Local experience in MRI-PIP is being applied similarly to CT scanning in Sudbury to improve efficiencies.

Excellent Care for All/Quality

Excellent Care for All/Quality (Readmission for Selected Case Mix Groups): Performance varied modestly from the set target for this indicator. Initiatives in Sudbury, such as the Congestive Heart Failure Clinic and Care Transitions Unit, are addressing this patient population and should have an impact on reducing readmissions to hospital. Case Managers in selected family health teams will contribute to earlier identification and treatment for frail elderly care. Deployment of Rapid Response Nurses (13) in Q1 will focus on the frail elderly with complex conditions and high risk of readmission to hospital. Telehomecare has engaged over 100 clients with heart failure or chronic obstructive pulmonary disease and will assist in keeping these residents healthier and reducing their risk of readmission to hospital.

Mental Health and Substance Abuse

Repeat Unplanned ER visits for Mental Health and Substance Abuse: Overall, repeat visits within 30 days to the emergency room for mental health and substance abuse conditions were within acceptable performance range. Initiatives deployed include: addictions counseling resources in Health Sciences North ER, enhanced Community Crisis Support in downtown Sudbury, Peer Support Counsellor in North Bay Regional Health Centre ER, Case Manager in the ER at Sault Area Hospital, and access to more hours for "safe" beds for detox patients in Timmins.

Access to Community Care

The wait time improved markedly in 2012/13 for North East Community Care Access Centre (NE CCAC) services for clients receiving home care in the community. Early in 2012/13, the NE CCAC identified the core client group that contributed to the longer wait time for the receipt of home care services in the community.

Community Engagement

The NE LHIN is accountable to the public's contributions to building a strong local system of care through ongoing community engagement efforts. The NE LHIN actively:

- Engages with its stakeholders and members of the public and connects their efforts to NE LHIN decision-making.
- Enhances awareness of health care issues across Northeastern Ontario communities through mutual information sharing.
- Identifies discussion items of mutual concern or interest.
- Regularly evaluates the effectiveness of community engagement activities.

Northern voices are the bedrock of our strategic plan. The primary focus of engagements during 2012/13 were the active participation in the NE LHIN's three-year strategic plan, the Integrated Health Service Plan:

- 50 engagement sessions – some by webinar and most face-to-face – that focused on validating IHSP priorities. Thousands of Northerners participated. These sessions were in addition to extensive engagements held in 2011 and early 2012.
- A bilingual survey that was widely publicized, showcased on our website, and attracted a total of 1,540 responses in both English and French.
- A 'virtual coffee break' by teleconference hosted by CEO Louise Paquette with Health Minister Deb Matthews and regional panelists to discuss Northeastern Ontario health care priorities.
- A close working relationship with the Réseau du mieux-être francophone du Nord de l'Ontario – the French Language Health Planning Entity for the North East and North West LHINs.
- A partnership with our Local Aboriginal Health Committee which includes members from across the region who represent Aboriginal, First Nation and Métis health service providers.
- More than 200 Northerners participating in engagement meetings with Dr. Samir Sinha, Provincial Seniors Care Strategy Lead.
- A partnership with the Ontario Medical Association to hold physician engagements.
- A partnership with the Centre for Addiction and Mental Health – Northern Ontario Area, on mental health and substance abuse engagement.
- An invitation to local District Social Service Advisory Boards (DSSABs) to provide input.
- An invitation to Public Health Units to provide input on local health care priorities.
- Helpful insights by the members of NE LHIN advisory committees who are experts/consumers in various health care areas in Northeastern Ontario.

Louise Paquette, NE LHIN CEO, and Dr. Samir Sinha, Provincial Seniors Strategy Lead, led a two-day trip to coastal communities in February 2013 to learn of the challenges facing older adults in coastal communities and to offer solutions to increase access to care.

Outcomes of our engagement efforts are reflected in our IHSP and the priorities that were established.

Community Engagement with Aboriginal/First Nation/Métis People

The NE LHIN Board of Directors is committed to an engagement process with Aboriginal/First Nations/Métis people that is respectful of language, nationhood, culture and spiritual beliefs.

The Aboriginal/First Nation/Métis population conservatively represents almost 10% of the NE LHIN population. The NE LHIN continues to focus on building meaningful relationships with Aboriginal/First Nation/Métis communities in an effort to improve the services and the health status of this population. The health care needs of Aboriginal communities across the region continue to be significant in scope and magnitude.

The main objective for targeting the needs of this population group is to improve health status and health outcomes by aligning existing Aboriginal/First Nations/Métis regional, provincial and federal health planning, program and service delivery structures. Among our Aboriginal population, many people are aging faster than the rest of the population, due to high rates of chronic diseases.

Engagements held in 2012/13 include:

- **IHSP:** Community engagements with the Aboriginal/First Nation/Métis community were held in Sudbury, Sault Ste. Marie, Timmins and North Bay. A special engagement with Dr. Samir Sinha, Provincial Seniors Care Strategy Lead, was also held with Aboriginal health leaders. In addition, the NE LHIN participated in priority setting engagements in James and Hudson Bay coastal communities, led by the Weeneebayko Area Health Authority (WAHA).
- **Local Aboriginal Health Committee:** In February 2013, LAHC members travelled from their communities across the region to Sudbury for a full-day face-to-face meeting with the NE LHIN CEO. Members were briefed on the latest health care developments and were asked for their input on moving forward in 2013/14.
- **Coastal Visit:** A two-day visit was held in February 2013 with Elders and people living in the coastal communities of Moosonee, Moose Factory, Peawanuck, Fort Albany and Kashechewan. Dr. Sinha, Provincial Seniors Strategy Lead, accompanied a LHIN team, which included the region's two geriatricians and the NE LHIN's CEO and Primary Care Lead. The visit focused primarily on the needs and challenges of delivering care to seniors, and subsequently identified solutions to increase access to care for the region's most northerly people.

109-year-old Granny Wabano chuckles at her photo in the NE LHIN's 2013-2016 strategic plan (Integrated Health Service Plan) with CEO Louise Paquette following a health care engagment at the Moosonee Elders Gathering Centre in February, 2013.

Community Engagement with our Francophone Population

The NE LHIN has the largest proportion of Francophones, at about 22%, of all LHINs in Ontario and is committed to enhancing access for Francophones to health services that are linguistically and culturally appropriate.

Engagements held in 2012/13 include:

- **IHSP:** The NE LHIN and the Réseau du mieux-être francophone du Nord de l'Ontario (RMEFNO) – the French Language Health Planning Entity – engaged with hundreds of Francophones either in person or through an online survey. Participants confirmed that French-language services (FLS) must remain an integral priority in 2013-2016 and be reflected in all LHIN activities to meet the needs of Francophones living in Northeastern Ontario.
    - During 10 community engagement sessions, participants were asked questions about access needs and solutions relating to French-language services.
    - Francophones participated in a bilingual survey, asking for their input on ways and means to increase access to care for Francophones.
- **Forum Engagement:** Two NE LHIN Forums – Chronic Disease Prevention and Management, and the Mental Health and Substance Abuse Forum – featured breakout sessions in French for Francophone health care providers in attendance. The RMEFNO assisted the LHIN with these breakout sessions as well as developing and helped to facilitate engagements with Francophones during the Forums.

André Lefebvre and Patricia McBride enjoy playing card games as a way to socialize and maintain connections with friends. Many of the region's Francophones (22%) actively participated in NE LHIN engagements sessions this past year and confirmed that increasing access to care in French is a regional priority.

Report on Integrated Health Service Plan Priorities

Alternate Level of Care Strategies and Solutions (ALC)

ALC patients are people in hospital beds who would be better cared for in an alternate setting such as long-term care, rehabilitation, assisted living or home. Having more home care and community services enables ALC patients to leave hospital sooner, making more beds available to patients who are waiting to be admitted to hospital.

Much progress was made in 2012/13 with the percentage of ALC days in acute care decreasing from over 30% to 20%. The NE LHIN continued its focus to help bring down rates of ALC patients through initiatives such as: home first, assisted living, integrated discharge planning, assess and restore beds, behavioural supports for long-term care facilities, case managers in selected family health teams and the introduction of two Health Links in Q4. Efforts will continue in 2013/14.

Highlights of 2012/13 ALC activities in the North East included:

- Peer Review of Health Sciences North in Sudbury: In July 2012, the NE LHIN called for the HSN peer review to address high rates of ALC patients at the hospital, challenges in moving patients from the emergency room through to discharge, and the overall impact of hospital operations on the community. Since the peer review report was released in October 2012, HSN, local partners, and the NE LHIN have been working to implement the report's recommendations to ensure positive patient-focused health care changes in Sudbury and area.
- The four HUB hospitals and NE CCAC have implemented a home first philosophy supported by integrated discharge planning processes between the hospitals and the CCAC. More than 1,300 patients have been sent home with the aid of these services and nearly 70% remain in community for more than 90 days. The two programs are a key care coordination priority for continued process improvement and expansion across hospital inpatient units.
- PATH (Priority Assistance to Transition Home) program – Canadian Red Cross set up an office at Health Sciences North for the delivery of the PATH to seniors who need help transitioning home.
- Two new nursing programs are now available in Northeastern Ontario dedicated to helping vulnerable patients, particularly older adults, manage their chronic conditions and receive timely post-acute care in their own homes. The innovative programs are supported by the North East LHIN and delivered by the North East CCAC. Telehomecare helps patients manage chronic heart and respiratory conditions through in-home monitoring equipment and health-coaching done by the registered nurses remotely. Rapid Response Nurses work to ease the transition from hospital to home in those critical first days after discharge.
- In June of 2012, the NE LHIN completed a review of the Rehabilitation and Complex Continuing Care systems in the North East and work has been underway to implement the report's recommendations and goals. The report is part of the NE LHIN's overall system planning and work to reduce emergency department wait times and the number of ALC patients, mainly the frail elderly, waiting in hospital for discharge.
- Community Investments: With higher than the provincial average of seniors in Northeastern Ontario, much of the LHIN's work is focused on investing in home and community services to better support seniors and the frail elderly including:
    - **Assisted Living:** Over the past fiscal year, the North East LHIN has invested in campus and mobile assisted living for 163 more high risk seniors, creating more capacity in community and helping to prevent older adults from being admitted to hospital.
    - **Transportation:** The NE LHIN has invested in transportation to help seniors in rural areas, where no or little public transportation exists, access medical appointments and groceries. This past year, the NE LHIN funded five new vans in the Cochrane Hub for seniors'

transportation, and one in Parry Sound.

- **Adult day programs:** These programs have expanded and additional investments have been made to provide meals on wheels services to seniors in their homes.

Emergency Department (ED) Wait Times

The region's four HUB hospitals continue to participate in the provincial ED Pay for Results program which supports a range of ED performance projects. Although there is a degree of variability between the hospitals, the region's overall ED performance is close to or below provincial wait time targets for admitted and non-admitted ED patients. Recognizing that ED demand and performance are also impacted by factors beyond the ED itself, the NE LHIN has supported two key community-oriented initiatives:

- Community Support System Navigators were introduced at HUB hospitals to facilitate successful ED and inpatient discharges, particularly for the frail elderly population needing multiple supports. Navigators help to ease system coordination challenges, support interdisciplinary service delivery, and build care team capacity.

- NE CCAC Care Coordinators located either within or adjacent to existing group practices. Care Coordinators are currently located part-time in three primary care venues: Community Health Centre (Sudbury East), Superior Family Health Team (Sault Ste. Marie) and City of Lakes Family Health Team (Sudbury). This model has been implemented within the offices of North East Specialized Geriatric Services.

Aboriginal/First Nation/Métis Health Services

From NE LHIN governance to staffing, Aboriginal/First Nations/Métis participation and guidance is entrenched within the NE LHIN organizational structure.

The NE LHIN's Local Aboriginal Health Committee (LAHC) advises the NE LHIN Board of Directors on health service priorities and opportunities for integration within Aboriginal/First Nation/Métis urban and rural communities.

Over the past year, the NE LHIN invested in increasing care for Aboriginal elders including:

- Assisted living for seniors and enhancing the Elders' Gathering Place Adult Day Centre in Moosonee and the Moose Cree First Nation in Moose Factory.
- Supporting the Shkagamik-Kwe Health Centre in Sudbury by funding a new Community Outreach Helper as part of the Mushkiki-gamik Outreach Support Team to support system navigation for elders.
- Coordinating a two-day visit by senior LHIN staff and five physicians to five coastal communities to better understand challenges in health care delivery, particularly for older adults, and to offer solutions. A subsequent internal action plan is guiding NE LHIN decisions and actions to increase access to care for the LHIN's most Northerly communities.

French Language Health Services – An Integrated Approach

The NE LHIN currently has 40 health service providers (HSPs) officially designated under the *French Language Services Act*, and has identified 63 other HSPs to work towards a FLS designation.

In 2012/2013, six HSPs (included in the 40) were designated by the government through an Order-in-Council – HSN, Nipissing Mental Health and Housing Support Services, and four Community Health Centres (CHCs). Three additional requests were supported by the NE LHIN – NE CCAC, St. Gabriel's Villa, and Sudbury East CHC – all of which are pending approval at the provincial government level.

In order to help ensure and monitor continuous improvement in the quality, accessibility and integration of FLS, the FLS accountability process was refined. Currently, 103 HSPs have a FLS performance indicator in their 2011-2014 Multi-Sectoral Service Accountability Agreements.

The NE LHIN continues to work with the five bilingual and Francophone Community Health Centres to implement a joint action plan and address challenges and opportunities in the sector, with a focus on integration. This plan will lead to

increased access to the primary health care sector for Francophones and will build on future initiatives with the NE LHIN's Primary Care Lead. The CHCs have expressed a keen interest in being active participants in primary care reform in Northeastern Ontario.

Addiction and Mental Health Services

The NE LHIN has implemented a number of "diversion" initiatives to decrease mental health and addictions consumer revisits to hospital emergency departments (ED). These investments include:

- A new addictions case manager and community addictions service provider in the Sudbury ED to assist staff to assess and redirect consumers.
- A mental health consumers' agency to place "peer" support workers in the ED at North Bay Regional Health Centre.
- A safe bed at Jubilee Centre in Timmins to take pressure off the Timmins and District Hospital ED.
- A mental health case manager at Algoma Public Health to work out of the Sault Area Hospital ED.
- A partnership with Health Sciences North and the Sudbury chapter of the Canadian Mental Health Agency to implement a centralized crisis service in the downtown core of the city of Greater Sudbury. This initiative is diverting people in crisis away from the hospital and decreasing the time police need to wait with people in distress in the ED. Funding was also provided to CMHA Sudbury to hire new crisis workers to work closely with hospital crisis staff.

The NE LHIN continued to work with the Ministry of Children and Youth Services, North Bay Regional Health Centre and community children's mental health services to move towards a decentralized model of children's mental health tertiary care. The beds were decentralized on April 1, 2013.

The NE LHIN continued to work with small hospitals to identify processes that will improve the provision of psychiatric consultations and access to schedule-one hospital inpatient mental health beds when appropriate. The NE LHIN is in the process of determining if a "bed registry" with CritiCall is feasible and useful for this purpose.

The Algoma Anchor Agency (integration of 13 addiction and mental health service providers) is proceeding well with an inaugural board of directors, a charter, and voluntary integration requests from 11 providers.

A Regional Mental Health and Addiction Consultation Group was formed and met for the first time in May 2012. The Group has members from across Northeastern Ontario to advise the NE LHIN on the implementation of the province's 10-year strategy *Open Minds, Healthy Minds*, and important regional mental health and addiction issues.

Behavioural Supports Ontario (BSO) is a program that offers a new way of caring for our most vulnerable – older adults with dementia, neurological conditions, substance abuse disorders, and mental illness – and provides help for their caregivers. The North East LHIN invested in 58 frontline workers, including new personal support worker coaches, nursing coaches, clinicians, psycho-geriatric resource consultants, and behaviour support facilitators. These care providers have been divided into four integrated response teams to serve geographic areas (Sudbury-Parry Sound-Manitoulin, Nipissing-Temiskaming, Cochrane and Algoma). Medical specialists are also linked to these teams. The North Bay Regional Health Centre, with its expertise in psycho-geriatrics, is coordinating BSO efforts across the region.

The NE LHIN is working with the NE CCAC on a new program which has seen the hiring of18 mental health nurses to provide support to children in 11 district school boards across the region.

Health Human Resources (HHR)

The lack of community support services, the need for increased integration, and the importance of recruitment and retention of our human resources emerged as leading themes in the NE LHIN's extensive community engagement sessions in 2012. Engagements identified the continued need for:

- readily accessible information of our workforce (supply and shortages);
- collaborative initiatives to leverage the human resource expertise already in the system; and

- reducing the duplication of efforts to access and retain our scare workforce.

The 2013-2016 IHSP includes HHR as one of three enablers for the plan's four priorities. Specific goals identified include:

1. Work with partners to develop a regional recruitment and retention strategy to ensure a more coordinated patient care across the continuum; and
2. Apply HHR strategies to support increased capacity for community-based care and ensure a more sustainable workforce in home and community support services sector.

The NE LHIN will continue to work with Health Force Ontario and educational instutions to help move collective HHR efforts forward and implement the IHSP's HHR enabler.

Optimize Surgical Services

The NE LHIN has been implementing recommendations from its review of surgical services delivered in hospitals throughout the region to ensure that access and quality of care are maintained in the future.

Priorities implemented in 2012/13 included:

Integrated orthopedic capacity plan -- The NE LHIN prepared an *Integrated Orthopedic Capacity Plan (IOCP)* with input from hospitals and orthopedic surgeons. The plan demonstrated that the NE LHIN can achieve its goals of reducing wait times and delivering quality care while providing care as close to home as possible. These goals will be achieved by repatriating volumes, improving reporting, and enhancing the role of the North East Joint Assessment Centre (NE JAC) and rehabilitation services.

Hip and Knees -- The five Joint Assessment Centres (JACs) are fully operational and located at Health Sciences North, North Bay Regional Health Centre, Sault Area Hospital, Timmins and District Hospital, and West Parry Sound Health Centre. The centres were able to implement a web-based referral tracking system to better coordinate referrals and collect the required data for reporting requirements. Patients, who previously waited between three and six months for an initial consult with an orthopaedic surgeon, can now be seen by an advanced practice physiotherapist within two to four weeks. In their short history, NE JACs have evaluated 5,000 people suffering from hip and knee problems. Once assessed, 64 per cent of clients in 2012/2013 were determined to be better suited for treatment other than surgery.

Call Schedule Project -- Work is ongoing on a call schedule for specialists across the region. Three main components have been identified as being essential for full implementation: identification of gaps in coverage by specialty areas; need for a web-based scheduler that can be adopted by NE LHIN hospitals; and the need for on-call standards across the region.

General Surgery Project -- Engagement with the surgeons is ongoing. The hospitals are developing a service realignment plan and have included general surgery as a priority. This project is being led by Nôtre Dame Hospital in Hearst and includes the development of a model to ensure viability of general surgery across the region. The focus has been on the Cochrane Hub, and to date, the project leads have met with the Cochrane Hub hospitals that provide general surgery, and the surgeons, to gather and validate surgical data. This information includes exploring opportunities to consolidate general surgery activities based on volumes, clarification of the role of small hospitals, on-call standards and recruitment opportunities. The hospitals and the surgeons provided feedback on how the model should unfold in the Cochrane Hub. A model will be confirmed and implemented in 2013/14.

Repatriation and Non-Urgent Inter-Facility Patient Transportation -- Both the surgical program and ED capacity and performance in the region are affected by patients being in the right place at the right time. This means getting patients into and out of referral centres on a timely basis. If this does not occur, patient flow is disrupted and beds that would otherwise be available are occupied due to a transportation issue as non-urgent transfers are low priority calls from an ambulance service perspective.

Non-Urgent Transportation has been a long-standing issue in the North East. In late 2012, the NE LHIN issued a call for expressions of interest to implement short-term pilot projects. Three pilots were selected in Timiskaming, Manitoulin-Sudbury and the City of Greater Sudbury. The results of these pilots will feed into a larger regional non-urgent inter-facility patient transportation review

and business planning process set to begin in early 2013/14. Through a collaborative effort with all partners (hospitals, long-term care homes, municipal service providers, ambulance/EMS, Ministry of Health and Long-Term Care), the NE LHIN is working to develop a made-in-the-North solution to this transportation challenge.

Electronic Medical Records

Given the North East region's large geography, dispersed population, and challenges retaining and recruiting health care professionals, the NE LHIN has embraced technology and electronic medical records as a key tool in transforming health care. A number of initiatives were undertaken over the past year.

- More than 49,000 patients were served using Telemedicine across 273 sites, a 42% increase from 2011/12. The NE LHIN remains the highest user of Telemedicine among Ontario's 14 LHINs.
- Telehomecare program – approximately 100 patients with heart failure and chronic obstructive pulmonary disease have been referred to this program within its first few months of having been launched. The NE LHIN is one of three LHINs in this initial roll-out.
- Expanded scope of Physician Office Integration (POI) project. West Parry Sound Health Centre (a non-Meditech site) joined POI, which brings our total to all 25 hospitals. The NE LHIN expanded the project to nurse practitioners and Community Health Centres. POI enables hospitals to send discharge summaries, lab and diagnostic imaging reports directly to the primary care provider's electronic medical record.
- More than 200 Telemedicine coordinators attended an Ontario Telemedicine Network Education Conference hosted by the NE LHIN, NW LHIN, and OTN in October of 2012.
- IT Integration and Alignment Council (IAC) was established and includes the participation of all 25 hospital CEOs and Chief Information Officers. The Council provides advice and recommends proposed solutions and deployment strategies for the region thereby increasing efficiency, standardization, shared purchasing/procurement and interoperability of systems.
- ALC Resource Matching and Referral project -- as part of Cluster 3 with the North West, South East, and Champlain LHINs. The NE LHIN agreed to future-state work flows for acute in-patient to complex continuing care, rehab, long-term care and home care. As a LHIN, we also participated in provincial standardization and achieved provincial minimum data set standardization for referral forms. The NE LHIN also compiled future state maps for discharge to community support services and mental health and addiction services.
- Worked with community care information management to deploy electronic assessment tools and business systems for community support services, mental health and addictions services, long-term care homes, community care access centre and small hospitals. The Integrated Assessment Record (IAR) is an application that allows authorized users to view multiple community-based assessments for a single patient.
- Supported the rollout of Ontario Lab Information System (OLIS) within the hospital sector. All hospitals are currently planning for or implementing a solution to submit laboratory results to OLIS as well as to improve access/viewing for clinicians.

Diabetes Strategy

In October 2012, the NE LHIN held its second regionally focused Chronic Disease Prevention and Management (CDPM) forum attended by close to 200 people. The event provided an overview of CDPM programs, identified both access and gaps to services, and related priorities. The sessions targeted health planners, hospitals, family health teams, health service providers, community health centres, and chronic disease-related organizations in the NE LHIN.

Responsibility for the Northern Diabetes Program was transferred to the NE LHIN in November of 2012 including 21 diabetes education programs and the Regional Coordinating Centre for diabetes. Since then, comprehensive work has been undertaken at the LHIN to:

- ensure seamless clinical service delivery during transition;
- improve coordination of care;
- increase access to more integrated diabetes programs; and
- identify and address both duplication and gaps of services.

NE LHIN Integration Activities

The NE LHIN continues to focus on integration efforts that support enhanced patient care, more seamless delivery of services and more coordinated clinical programs for patients and consumers of health care.

In 2012/13, the NE LHIN Board of Directors approved the following voluntary integrations:

Integration of Thessalon and Matthews Memorial Hospitals to Blind River District Health Centre
This integration of hospital operations involves the transfer of programs and services previously delivered by the Sault Area Hospital. The transfer of Thessalon and Matthews Memorial operations into the Blind River District Health Centre will help to focus decision-making and planning for rural health services by a small, rural hospital. Previously, the NE LHIN held community engagements throughout the catchment area to introduce the concept of a rural health model for the North Shore Algoma Area.

Integration between the Timiskaming Palliative Care Network and the Kirkland and District Hospital
This integration will increase service provision, sustainability and the continuum of care. The Timiskaming Palliative Care Network, funded by the NE LHIN, had been providing visiting hospice services to the Timiskaming District since 1989. It works closely with care providers and clients across the district to provide expertise and resources in palliative and end-of-life care. It has been located at the Kirkland and District Hospital for the past 20 years.

Integration between the Hôpital de Mattawa and La Maison des Ainés de Mattawa Seniors Living
The hospital purchased and integrated with the Algonquin Nursing Home. Since then, a not-for-profit corporation (La Maison des Ainés de Mattawa Seniors Living (La Maison) was created. This integration means that one CEO will fill the role of the administrator of the nursing home and the hospital -- creating a more efficient process and realizing savings that can be passed on to residents. The CEO will also be supported by one shared senior administrative team.

Service Integration between the Algoma Manor Nursing Home and the Physically Handicapped Adults' Rehabilitation Association (PHARA)
In Thessalon, the Algoma Manor Nursing Home transferred their Meals on Wheels service to PHARA. This horizontal integration relocates the program to an agency with a similar mandate, and will enhance community-based health services, increase program efficiency and improve client satisfaction.

In addition to the integrations above, and following extensive community engagements, much ground-work was laid in 2012/13 to realign health care services in the interest of enhanced patient care, including:

Collaboration and integration between three hospitals and health service providers in the district of Temiskaming. The NE LHIN Board approved a Temiskaming Realignment Plan in June 2012 with the goal of transitioning to an improved patient-focused local system, fewer pressures on system providers, and increased access and care across the district. Some of the associated projects include:

- Integration of three hospitals: Englehart, Kirkland, and Temiskaming Hospitals.
- Integration of mental health and substance abuse providers.
- Adoption of Health Links model for coordination of clinical care for more people.

Collaboration and integration between rural hospitals and health service providers in the district of Cochrane. The NE LHIN Board approved a Cochrane Realignment Plan in June 2012 with the goal of transitioning to an improved patient focused local system, fewer pressures on system providers, and increased access and care across the district. Some of the associated projects include:

- Integration of Timmins Mental Health Cluster
- Integration of addictions agencies in Hearst, Kapuskasing, Smooth Rock Falls
- Integration discussions with Timmins Alzheimer's Society

- Adoption of Health Links model for coordinating rural care.

Collaboration and integration between rural hospitals and health service providers in the district of Algoma. Some of the associated projects include:

- Integration discussion among three hospitals: Hornepayne, Chapleau, and Lady Dunn Health Centre
- Integration discussions regarding Sault Ste. Marie Alzheimer's Society
- Adoption of Health Links model for coordinating rural care.

Collaboration and integration of hospital services and health service providers in the district of Sudbury and Parry Sound / Nipissing. Some of the associated projects include:

- Integration of the North East Specialized Geriatric Services from the City of Sudbury to North Bay Regional Health Centre
- Integration of the Sudbury addiction's agencies
- Integration between Warmhearts and Maison Vale Hospice
- Integration of Sudbury and North Bay Alzheimer's Societies
- Adoption of Health Links model for coordinating care.

Anne Hartman, 96, a resident at La Maison des Ainés Mattawa Seniors Living, as well as Vice President of the Resident Council, talks about the success that's been achieved through collaboration and communication with the integration between the Hôpital de Mattawa Hospital and La Maison des Ainés de Mattawa Seniors Living.

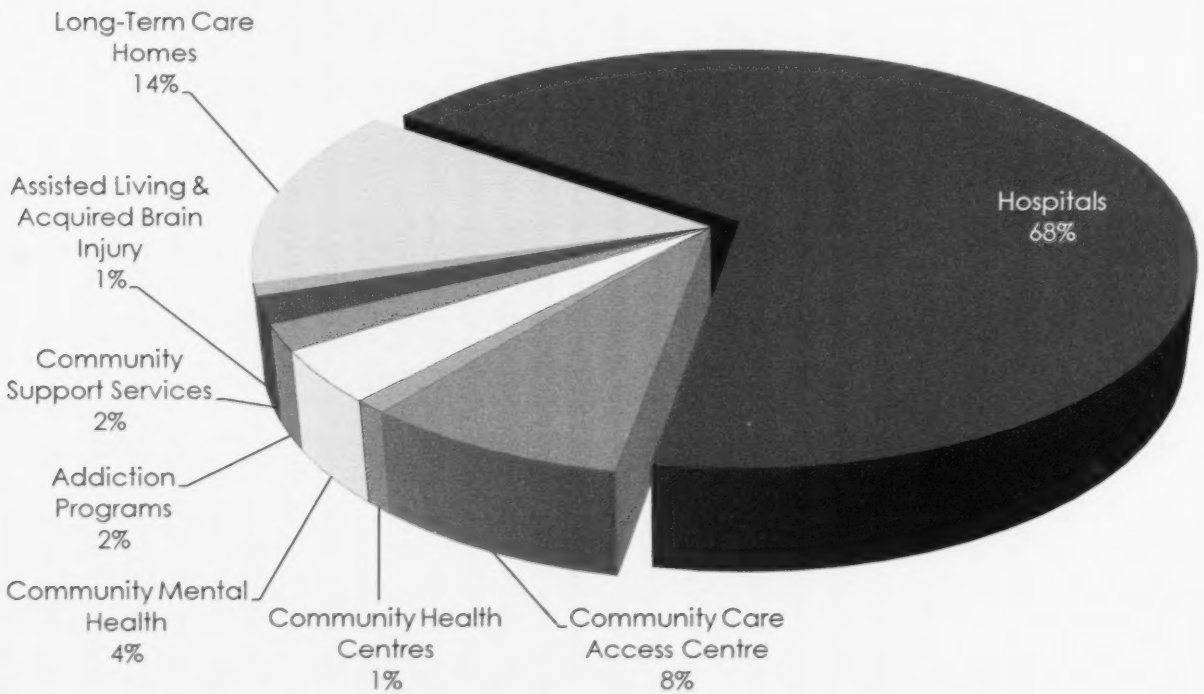
Analysis of LHIN Operational Performance

The NE LHIN ended the 2012/13 year with a balanced position. Offices in North Bay, Sault Ste. Marie, Sudbury and Timmins have enabled LHIN staff to connect more frequently throughout the year with health service providers and fellow Northerners.

Through extensive community engagement efforts, our 42 staff were able to gather information that allowed the LHIN to direct funding to projects that would improve patient care and advance a more integrated and efficient delivery of services for people. Engagements also helped to set priorities for 2012/13 and respond to the health care needs of fellow Northerners.

Our NE LHIN has established three physician leads with a focus on critical care, emergency departments and primary care. Their contribution and insight are assisting the NE LHIN in making decisions to improve the quality of care and enhance access to care for Northerners.

Every year, the NE LHIN provides 1.4 billion dollars to 156 health service providers to close to 190 health programs across northeastern Ontario.


Long-Term Care Homes 14%
Assisted Living & Acquired Brain Injury 1%
Community Support Services 2%
Addiction Programs 2%
Community Mental Health 4%
Community Health Centres 1%
Community Care Access Centre 8%
Hospitals 68%

Financial statements of

North East Local Health Integration Network

March 31, 2013

North East Local Health Integration Network

March 31, 2013

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Independent Auditor's Report

To the Members of the Board of Directors of the
North East Local Health Integration Network

We have audited the accompanying financial statements of the North East Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2013, and the statements of financial activities, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of LHIN as at March 31, 2013, and the results of its financial activities, change in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
May 23, 2013

North East Local Health Integration Network

Statement of financial position
as at March 31, 2013

	2013	2012
	$	$
Financial assets		
Cash	**891,035**	360,696
Due from the LHIN Shared Services Office (Note 3)	**-**	466
Accounts receivable	**7,692**	16,431
HST Receivable	**70,904**	39,867
Due from MOHLTC-Health Service Providers ("HSP") (Note 7)	**1,537,653**	7,992,935
	2,507,284	8,410,395
Liabilities		
Accounts payable and accrued liabilities	**743,020**	358,087
Due to MOHLTC & eHealth Ontario(10b, 10c)	**219,907**	76,904
Due to the LHIN Shared Services Office (Note 3)	**28,155**	-
Due to Health Service Providers ("HSP") (Note 7)	**1,537,653**	7,992,935
Deferred capital contributions (Note 4)	**232,212**	165,466
	2,760,947	8,593,392
Net debt	**(253,663)**	(182,997)
Commitments (Note 13)		
Non-financial assets		
Prepaid expenses	**21,451**	17,531
Tangible capital assets (Note 5)	**232,212**	165,466
	253,663	182,997
Accumulated surplus	**-**	-

Approved by the Board

_____ Director

_____ Director

The accompanying notes to the financial statements are an integral part of these financial statements.

North East Local Health Integration Network

Statement of financial activities
year ended March 31, 2013

	Budget (Note 6)	2013 Actual	2012 Actual
	$	$	$
Revenues			
MOHLTC funding			
HSP transfer payments (Note 7)	1,380,587,300	1,420,730,615	1,380,862,148
Operations of LHIN	4,752,782	4,746,290	5,002,882
Enabling technologies (Note 9a)	-	580,000	600,000
Behavioural Support Ontario (Note 9b)	-	-	72,000
French Language Health Service (Note 9c)	296,800	296,800	296,800
Réseau du mieux-être francophone du Nord de l'Ontario (Note 9d)	796,159	796,159	802,973
Emergency Department Lead (Note 9e)	75,000	75,000	75,000
Critical Care Lead (Note 9f)	75,000	75,000	75,000
Aboriginal Engagement (Note 9g)	100,000	100,000	100,000
Emergency Room/Alternate Level of Care (Note 9h)	100,000	100,000	100,000
Primary Care Lead (Note 9i)	75,000	75,000	43,750
Diabetes Regional Coordinating Centre (Note 9j)	-	393,346	-
Amortization of deferred capital contributions (Note 4)	59,400	88,600	60,678
	1,386,917,441	1,428,056,810	1,388,091,231
In year surplus recovered by MOHLTC (Note 10)	-	-	(31,750)
Funding repayable to MOHLTC and eHealth Ontario (Note 10)	-	(219,907)	(76,904)
	1,386,917,441	1,427,836,903	1,387,982,577
Expenses			
Transfer payments to HSPs (Note 7)	1,380,587,300	1,420,730,615	1,380,862,148
General and administrative (Note 8)	4,752,782	4,746,290	5,002,882
Enabling technologies (Note 9a)	-	580,000	539,451
Behavioural Support Ontario (Note 9b)	-	-	72,000
French Language Health Service (Note 9c)	296,800	296,800	296,800
Réseau du mieux-être francophone du Nord de l'Ontario (Note 9d)	796,159	796,159	786,618
Emergency Department Lead (Note 9e)	75,000	75,000	72,000
Critical Care Lead (Note 9f)	75,000	73,003	72,000
Aboriginal Engagement (Note 9g)	100,000	100,000	100,000
Emergency Room/Alternate Level of Care (Note 9h)	100,000	100,000	100,000
Primary Care Lead (Note 9i)	75,000	65,280	18,000
Diabetes Regional Coordinating Centre (Note 9j)	-	185,156	-
Amortization of tangible capital assets	59,400	88,600	60,678
	1,386,917,441	1,427,836,903	1,387,982,577
Annual surplus and accumulated surplus, end of year	-	-	-

The accompanying notes to the financial statements are an integral part of these financial statements.

North East Local Health Integration Network

Statement of change in net debt
year ended March 31, 2013

	2013	2012
	$	$
Annual surplus	-	-
Acquisition of tangible capital assets	**(155,346)**	-
Amortization of tangible capital assets	**88,600**	60,678
Increase in prepaid expenses, net	**(3,920)**	(16,853)
(Increase) decrease in net debt	**(70,666)**	43,825
Net debt, beginning of year	**(182,997)**	(226,822)
Net debt, end of year	**(253,663)**	(182,997)

The accompanying notes to the financial statements are an integral part of these financial statements.

North East Local Health Integration Network

Statement of cash flows
year ended March 31, 2013

	2013	2012
	$	$
Operating transactions		
Annual surplus	-	-
Items not affecting cash		
Amortization of tangible capital assets	**88,600**	60,678
Amortization of deferred capital contributions (Note 4)	**(88,600)**	(60,678)
Changes in non-cash working capital		
Decrease in due from the LHIN Shared Service Office	**466**	1,166
Decrease in accounts receivable	**8,739**	51,288
(Increase) decrease in HST Receivable	**(31,037)**	69,939
Decrease in due from MOHLTC-Health Service Providers	**6,455,282**	12,705,062
Increase in prepaid expenses	**(3,920)**	(16,853)
(Increase) decrease in accounts payable and accrued liabilities	**232,409**	(275,476)
Increase (decrease) in due to MOHLTC & eHealth Ontario	**143,003**	(283,312)
Increase in due to the LHIN Shared Service Office	**28,155**	-
Decrease in due to Health Service Providers	**(6,455,282)**	(12,705,062)
	377,815	(453,248)
Capital transaction		
Acquisition of tangible capital assets	**(2,822)**	-
Financing transaction		
Increase in deferred capital contributions (Note 4)	**155,346**	-
Net increase (decrease) in cash	**530,339**	(453,248)
Cash, beginning of year	**360,696**	813,944
Cash, end of year	**891,035**	360,696

The accompanying notes to the financial statements are an integral part of these financial statements.

1. Description of business

The North East Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the North East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the area of Northeastern Ontario. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with Ministry-LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC") and provides the framework for the LHIN accountabilities and activities. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed Health Service Providers ("HSP") in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2013.

The LHIN statements do not include any MOHLTC managed programs.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible assets and losses in the value of assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the statement of financial activities, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method

For assets acquired and brought into use during the year, amortization is provided for a full year.

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of financial activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

2. Significant accounting policies (continued)

Adoption of new accounting standards

As at April 1, 2012, the LHIN adopted Public Sector Accounting Handbook *Section PS 1201, "Financial Statement Presentation"*, Section PS 2601 *"Foreign Currency Translation"*, PS 3410 *"Government Transfers"* and Section PS 3450, *"Financial Instruments"*. There was no impact of the adoption of these new standards on the financial statements.

3. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the LHIN Collaborative (LHINC) are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs, are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portions of the LSSO/LHINC operating costs overpaid (or not paid) by the LHIN at the year-end are recorded as a receivable from (payable to) the LSSO/LHINC. This is all done pursuant to the agreement the LSSO/LHINC has with all the LHINs.

4. Deferred capital contributions

	2013	2012
	$	$
Balance, beginning of year	**165,466**	226,144
Capital contributions received	**155,346**	-
Amortization	**(88,600)**	(60,678)
Balance, end of year	**232,212**	165,466

5. Tangible capital assets

			2013	2012
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Furniture and fixtures	**165,521**	**115,163**	**50,358**	38,603
Computer equipment	**142,000**	**111,748**	**30,252**	-
Leasehold improvements	**1,064,315**	**912,713**	**151,602**	126,863
	1,371,836	**1,139,624**	**232,212**	165,466

Non-cash transactions

During the year, tangible capital assets were acquired at an aggregate cost of $155,346 (2012 - $Nil) of which $152,524 (2012 - $Nil) were paid after year-end and $2,822 (2012 - $Nil) were paid during the year.

6. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the statement of financial activities reflect the initial budget at April 1, 2012. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $1,420,730,615 is made up of the following:

	$
Initial HSP Funding budget	1,380,587,300
Adjustment due to announcements made during the year	40,143,315
	1,420,730,615

The total operating budget of $7,237,595 is made up of the following:

Initial budget	6,270,741
Additional funding received during the year	1,122,200
Amount treated as Capital Contribution	(155,346)
Total budget	7,237,595

7. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $1,420,730,615 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

	2013	2012
	$	$
Operation of Hospitals	**953,579,910**	931,799,098
Grants to compensate for Municipal Taxation - Public Hospitals	**239,625**	239,625
Long Term Care Homes	**206,007,661**	201,330,568
Community Care Access Centres	**119,827,431**	115,762,445
Community Support Services	**27,192,174**	25,759,201
Acquired Brain Injury	**2,675,799**	2,424,099
Assisted Living Services in Supportive Housing	**17,079,979**	14,043,889
Community Health Centres	**17,733,603**	16,736,495
Community Mental Health	**54,037,471**	51,687,216
Substance Abuse & Gambling Problem	**22,356,962**	21,079,512
	1,420,730,615	1,380,862,148

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2013, an amount of $1,537,653 (2012 - $7,992,935) was receivable from the MOHLTC and was payable to the HSPs. These amounts have been reflected as revenue and expenses in the statement of financial activities and are included in the table above.

8. General and administrative expenses

The statement of financial activities presents the expenses by function; the following classifies these same expenses by object:

	2013	2012
	$	$
Salaries and wages	**2,997,634**	3,147,545
HOOPP	**280,940**	277,710
Other benefits	**316,553**	324,458
Staff travel	**133,817**	178,767
Governance travel	**9,214**	18,524
Communications	**86,888**	66,264
Accommodation	**207,443**	195,058
Advertising	**24,979**	46,969
Consulting fees	**58,907**	50,659
Equipment rentals	**18,695**	18,997
Board Chair per diems	**-**	21,375
Other Governance per diems	**4,100**	17,510
Insurance	**5,977**	16,337
LHIN Shared Services Office	**341,520**	382,525
LHIN Collaborative	**47,500**	26,971
Other meeting expenses	**47,908**	44,154
Other governance expenses	**8,185**	36,440
Printing and translation	**70,799**	55,895
Staff development	**22,695**	18,896
IT equipment	**14,794**	20,895
Office supplies and equipment	**30,182**	24,995
Other	**17,560**	11,938
	4,746,290	5,002,882

9. a) Enabling technologies

MOHLTC provided $580,000 to the LHIN. The LHIN has four permanent full-time staff to run a Project Management Office related to Enabling technologies. In addition to covering the staff costs, the LHIN also incurred costs related to projects this group is responsible for. The total amount of expenses the LHIN incurred related to Enabling technologies was $580,000.

b) Behavioural Support Ontario (BSO)

The LHIN did not receive funding from the Ministry of Health and Long-Term Care to support the BSO project in 2012/13.

c) French Language Health Services (FLHS)

The LHIN received $296,800 from the Ministry of Health and Long-Term care to support French Language Health Services programs. With these funds the LHIN employs three full-time staff to work on this file. In addition the funds were used to cover travel and other staff related costs. The total amount of expenses incurred related to FLHS was $296,800.

9. **d) Réseau du mieux-être francophone du Nord de l'Ontario**

The LHIN received $796,159 from the Ministry of Health and Long-Term Care to fund the operation of the Réseau du mieux-être francophone du Nord l'Ontario, these funds were spent in full.

e) Emergency Department Lead (ED Lead)

The Ministry of Health and Long Term Care provided the LHIN $75,000 in one-time funding to pay the LHIN ED Lead. The LHIN contracted an area physician as the ED Lead; total monies paid out in 2012/13 are $75,000.

f) Critical Care Lead (CC Lead)

The Ministry of Health and Long Term Care provided the LHIN $75,000 in one-time funding to pay the LHIN CC Lead. The LHIN contracted an area physician as the CC Lead; total monies paid out in 2012/13 are $73,003.

g) Aboriginal Engagement

The Ministry of Health and Long Term Care provided an additional $100,000 in base funding for the purposes of engaging the Aboriginal population and organizations within the North East LHIN. The total amount of expenses paid using this funding was $100,000.

h) Emergency Room/Alternate Level of Care (ER/ALC)

The Ministry of Health and Long Term Care provided $100,000 in one-time funding to help the LHIN in supporting the North East ER/ALC Performance Lead, this amount was spent in full.

i) Primary Care Lead (PC Lead)

The Ministry of Health and Long Term Care provided the LHIN $75,000 in one-time funding to pay the LHIN PC Lead to support the Primary Care LHIN Lead Program. The LHIN contracted an area physician as the PC Lead; total monies paid out in 2012/13 are $65,280.

j) Diabetes Regional Coordinating Centre (RCC)

The Ministry of Health and Long Term Care provided the LHIN $542,200 in one-time funding to support the LHIN in achieving the RCC program goals and objectives. During the year $185,156 of expenses were incurred plus $148,854 in capital expenditures.

10. Funding repayable to the MOHLTC

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC is made up of the following components:

	Funding received	Eligible expenses	Excess funding
	$	$	$
Transfer payments to HSPs	**1,420,730,615**	**1,420,730,615**	**-**
LHIN operations	**4,746,290**	**4,746,290**	**-**
Amortization of capital assets	**88,600**	**88,600**	**-**
Enabling technologies	**580,000**	**580,000**	**-**
French Language Health Service	**296,800**	**296,800**	**-**
Réseau du mieux-être francophone du Nord l'Ontario	**796,159**	**796,159**	**-**
Emergency Department Lead	**75,000**	**75,000**	**-**
Critical Care Lead	**75,000**	**73,003**	**1,997**
Aboriginal Engagement	**100,000**	**100,000**	**-**
Emergency Room/Alternate Level of Care	**100,000**	**100,000**	**-**
Primary Care Lead	**75,000**	**65,280**	**9,720**
Diabetes Regional Coordinating Centre	**393,346**	**185,156**	**208,190**
	1,428,056,810	**1,427,836,903**	**219,907**

b) The amount due to the MOHLTC is made up of the following components:

	2013	2012
	$	$
Opening balance	**16,355**	360,216
In-Year funds repayable to MOHLTC	**-**	31,750
Funding recovered by the MOHLTC	**(16,355)**	(391,966)
Funding repayable to the MOHLTC (Note 10A)	**219,907**	16,355
Closing balance	**219,907**	16,355

c) The amount due to eHealth Ontario is made up of the following components:

	2013	2012
	$	$
Opening balance	**60,549**	-
Funding recovered by eHealth Ontario	**(60,549)**	-
Funding repayable to the eHealth Ontario (Note 10A)	**-**	60,549
Closing balance	**-**	60,549

11. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 49 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2013 was $358,749 (2012 - $348,703) for current service costs and is included as an expense in the statement of financial activities. The last actuarial valuation was completed for the plan as at December 31, 2012. At that time the plan was fully funded.

12. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in the favor of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

13. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Minimum lease payments due under the building and equipment lease are as follows:

	$
2014	292,118
2015	223,250
2016	102,661
2017	59,500
2018	60,917
Thereafter	328,667
	1,067,113

The LHIN also has funding commitments to HSPs associated with accountability agreements. As of March 31, 2013 the LHIN had signed Accountability Agreements with all Hospitals, Long-Term Care Home and Community Agencies. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from MOHLTC.